**Kentucky Teachers' Retirement System**

# Request for Qualifications (RFQ)

**for**

# 2007 Health Plan Services for Medicare Eligible Retirees RFQ

**Inquiry Due Date: July 07, 2006, 04:30 p.m., E.D.T.**

**Response Due Date: July 31, 2006, 04:00 p.m., E.D.T.**

## SECTION ONE
## GENERAL INFORMATION

### 1.1 INTRODUCTION AND BACKGROUND

The Kentucky Teachers' Retirement System ("KTRS" or "Fund") is soliciting qualifications from all insurance carriers interested in being selected to provide the health plan services for Medicare eligible participants described in Attachment A through A6.

KTRS is an independent agency and instrumentality of the Commonwealth of Kentucky that was established July 1, 1940. KTRS provides pension and medical benefits to the state's retired educators. KTRS serves approximately 72,000 active members, 4,000 inactive members, and 38,000 benefit recipients with approximately half of those being Medicare eligible.

KTRS' current self-funded Medicare Eligible Health Plan pays medical claims secondary to the traditional Medicare plan. The Medicare Modernization Act created new and innovative solutions that are worthy of our consideration when evaluating KTRS' retiree medical strategy. Private Fee For Service is a Medicare Advantage plan under which the participant will be covered for eligible health care services rendered by any provider that accepts Medicare assignment and the administrative terms of a health plan that meets Medicare's requirements. A Private Fee For Service plan is required to offer benefits that are at a minimum actuarially equivalent to the traditional Medicare program. Under special employer waivers, the design of a Private Fee For Service plan can be enhanced to meet an individual plan sponsor's design objectives as long as the resulting plan meets Medicare's minimal coverage requirements. Private Fee For Service plans are under the Part C of Medicare umbrella. In order to entice insurance carriers to cover more rural counties throughout the United States, Medicare provides more subsidies for the Medicare Advantage plans as opposed to the traditional Medicare plan. With a Private Fee For Service plan, Medicare renders capitated payments for administering a beneficiary's benefits. However, rather than building out an independent provider network, Private Fee For Service plans utilize traditional Medicare's participating physicians and provider payment rates.

The Medicare Advantage plan product has been well received by insurance carriers in 2006, producing a competitive environment. With a Medicare Advantage plan, the KTRS participants are still in the Medicare program, will still have Medicare rights and protections, and will still get all the regular Medicare-covered services. Under the new Medicare Advantage bidding process, Medicare establishes a benchmark for local and regional Medicare Advantage plans. For local Medicare Advantage plans, the Medicare Advantage area-specific non-drug benchmark amount is equal to the monthly Medicare Advantage capitation rate for the local area. When multiple service areas are involved, a weighted average benchmark is established. If a bid submitted by a Medicare Advantage plan is lower than the benchmark, 75% of the difference is a rebate amount that must be used to:

- provide extra benefits,

- reduce the beneficiary's cost sharing for Parts A & B services,
- reduce the beneficiary's Part B premium,
- reduce the beneficiary's premium for the plan's supplemental benefits;
- or, a combination of the above.

Given the information above, the KTRS Board of Trustees has approved the issuance of this RFQ. This RFQ has no affect on the existing self-funded KTRS Prescription Drug Plan. The KTRS self-funded Medicare Eligible Prescription Drug Plan, currently administered by Medco, will remain intact for all eligible participants over the age of 65, regardless of their medical plan coverage. KTRS Insurance staff will continue to bill Medicare for the Part D Drug Subsidy in 2006 and 2007.

**1.2 ISSUER**

KTRS has issued this RFQ in accordance with Kentucky statutes governing KTRS' administration. The staff of KTRS has prepared the content herein. One (1) copy of this RFQ may be provided free of charge from KTRS by contacting:

Jane Cheshire Gilbert
479 Versailles Road
Frankfort, Kentucky 40601
Phone: (502) 848-8500
Fax: (502) 573-0199
Email: jane.gilbert@ky.gov

A nominal fee will be charged for providing additional paper copies.

**1.3 DUE DATE AND FORMAT FOR QUALIFICATIONS**

**All responses must be received at the address below no later than July 31, 2006, at 04:00 p.m., E.D.T.** Each respondent must submit one original (marked "Original"), one copy of the response in CD ROM format, and four paper copies of the response, including the transmittal letter and other related documentation as required by this RFQ. The response must be addressed/delivered to:

Jane Cheshire Gilbert
Medical Risk Specialist
Kentucky Teachers' Retirement System
479 Versailles Road
Frankfort, KY 40601

Any response received after the due date will not be considered. Any late responses will be returned, unopened, to the respondent, upon request, within thirty days of filing.

**1.4 MODIFICATION OR WITHDRAWAL OF OFFERS**

Responses to this RFQ may be modified or withdrawn in writing or by fax notice received prior to the date specified for receipt of responses. The respondent's authorized representative may also withdraw the response in person, providing his or her identity is made known and he or she signs a receipt. Responses may not be withdrawn after the response due date has passed.

Modification to or withdrawal of a response received after the date specified for receipt of responses will not be considered. If it becomes necessary to revise any part of this RFQ or if additional data is necessary for an exact interpretation of provisions of this RFQ prior to the due date for responses, a supplement will be posted by KTRS on its website (www.ktrs.ky.gov). If such supplemental issuance is necessary, KTRS reserves the right to extend the due date for responses to accommodate such interpretations or additional data requirements. The respondent's inquiry period ends July 7, 2006 at 04:30 p.m. E.D.T.

## 1.5 JOINT BIDS AND USE OF SUBCONTRACTORS

A respondent may not join with any other related or non-related insurance carriers in responding to the insured Medicare Advantage plan and self-funded Medicare Eligible Health Plan components of this RFQ. The respondent must be able to provide both plan components required in this RFQ. If a respondent responds with the ability to provide only one of the plan components required in this RFQ, the respondent's proposal will not be considered.

Smaller functions within the two plan components such as subrogation or COBRA administration may be subcontracted at the discretion of any awarded bidder. Any planned or proposed use of subcontractors must be clearly documented in the bid, including the name of the subcontractor. The prime contractor shall be completely responsible for all contract services to be performed.

## 1.6 CONFIDENTIAL INFORMATION

Respondents are advised that materials contained in responses are subject to the Kentucky Public Records Act, KRS 61.870 to 61.884, and, after the contract award if any, may be viewed and copied by any member of the public, including news agencies and competitors. Respondents claiming a statutory exception to the Kentucky Public Records Act must place all confidential documents (including the requisite number of copies) in a sealed envelope clearly marked "Confidential" and must indicate in the transmittal letter and on the outside of that envelope that confidential materials are included. The respondent must also specify in the transmittal letter which statutory exception provision applies. KTRS reserves the right to make final determinations of confidentiality. If KTRS does not agree that the information designated is confidential under one of the disclosure exceptions to the Kentucky Public Records Act, it may either reject the response or discuss its interpretation of the allowable exceptions with the respondent. If agreement can be reached, the response will be considered. If agreement cannot be reached, KTRS will remove the response from consideration for award and return the response to the respondent.

KTRS will not consider information regarding fees, pricing, premiums, premium equivalents and any other forms of remuneration to be confidential information.

Respondents understand and agree that data, materials, and information disclosed in this RFQ may contain confidential and protected information. The respondents covenant that data, material and information gathered, based upon or disclosed to the respondent for the purpose of this RFQ, will not be disclosed to or discussed with third parties without the prior written consent of KTRS.

**1.7 RFQ RESPONSE COSTS**

KTRS accepts no obligations for costs incurred by respondents.

**1.8 TAXES**

KTRS is exempt from federal, state, and local taxes. KTRS will not be responsible for any taxes levied on the respondent as a result of any contract resulting from this RFQ.

**1.9 DISCUSSION FORMAT**

KTRS reserves the right to conduct discussions, either oral or written, with those respondents determined by KTRS to be qualified to perform the services described in Attachment A through A6. KTRS also reserves the right to conduct clarifications to resolve minor issues.

**1.10 CALENDAR**

The following is the expected timeline for the RFQ and this timeline is subject to change at the discretion of KTRS.

| ACTIVITY | COMPLETION DATE |
|---|---|
| RFQ published/released | July 01, 2006 |
| Respondent's inquiry period ends | July 07, 2006 04:30 p.m. E.D.T |
| Answers distributed | July 11, 2006 |
| Respondent's response period ends | July 31, 2006 04:00 p.m. E.D.T. |
| Discussions and evaluations | August, 2006 |
| Determination of qualifications | September, 2006 |
| Qualified bidders negotiations (if any) | September, 2006 |
| Notify selected respondent (if any) | September, 2006 |
| Contract negotiation (if any) | September, 2006 |
| Contract signed (if any) | October, 2006 |
| Contract effective date (if any) | January 01, 2007 |

## 1.11 TERMS and CONDITIONS

The information contained in this RFQ may include estimates, projections, subjective judgment and/or analysis, which may or may not be correct. KTRS makes no representations or warranties, expressed or implied, as to the accuracy or completeness of the information in the RFQ and nothing contained herein is or shall be relied upon as a promise or representation, whether as to the past or the future. The RFQ does not purport to contain all of the information that may be required to evaluate the RFQ and any recipient hereof should conduct their own independent analysis of KTRS and the data contained or referenced herein. KTRS does not anticipate updating or otherwise revising the RFQ. However, this RFQ may be withdrawn, modified, or re-circulated at any time at the sole discretion of KTRS.

KTRS is not and will not be under any obligation to accept, review or consider any response to this RFQ, and is not and will not be under any obligation to accept the lowest offer submitted or any offer at all. KTRS is not and will not be under any obligation to any recipient of, or any respondent to, the RFQ except as expressly stated in any binding agreement ultimately entered into, either as part of this RFQ process, or otherwise.

Any response submitted will become the property of KTRS. KTRS reserves the right to retain all responses submitted, and to use any information contained in a response except as otherwise prohibited by law. KTRS shall have the right to use all ideas, or adaptations of those ideas, contained in any proposals received in response to this RFQ without remuneration. Selection or rejection of the RFQ will not affect this right.

## SECTION TWO
## RESPONSE PROCEDURES

### 2.1 INQUIRIES ABOUT THE RFQ

All inquiries and requests for information regarding this RFQ must be submitted in writing by e-mail to:

Jane Cheshire Gilbert
Medical Risk Specialist
jane.gilbert@ky.gov

no later than July 07, 2006, at 04:30 p.m. E.D.T. KTRS reserves the right to judge whether any questions should be answered in writing, and any such written answers will be posted by KTRS on its website (www.ktrs.ky.gov). Inquiries are not to be directed to any staff or Board member of KTRS, except as outlined in this section. Such unauthorized communications may disqualify respondent from further consideration. KTRS reserves the right to discuss any part of any response with a particular respondent for the purpose of clarification. Respondents will be given equal access to any necessary communications about the RFQ that take place between KTRS and other respondents.

### 2.2 DETERMINATION OF QUALIFICATIONS

Based on the responses to the RFQ process, KTRS will identify respondents deemed qualified to perform the health plan services for our Medicare eligible participants described in Attachments A through A6. KTRS reserves the right to reject any or all proposals in whole or in part on any basis that is determined by KTRS to be in the best interest of the KTRS participants and the KTRS health plan. KTRS reserves the right to reject any or all responses regardless of qualifications or award this bid in whole or in part for 2007 and/or a future year.

## SECTION THREE
## RESPONSE PREPARATION INSTRUCTIONS

### 3.l GENERAL

To facilitate the timely evaluation of responses, a standard format for submission has been developed and is documented in this section. All respondents are required to format their responses in a manner consistent with the guidelines described below:

· Each item must be addressed in the respondent's response, or the response may be rejected.

· The transmittal letter should be in the form of a letter. The response must be organized under the specific section titles as listed below.

**A complete response will include the following:**

1. Hard copy submission of a transmittal letter (with the information in Section 3.2)
2. Hard copy submission of a response (with the information and attachments described in Section 3.3)
3. Completed Minimum Qualifications Certificate encompassed in Attachments A through A6 (Section 3.3)
4. Original, four copies, and one CD ROM of entire response as outlined in Section 1.3. The original must be so marked and must contain original signatures.
5. Any portion of the response related to actual costs, pricing, premiums, premium equivalents, fees, administration charges, and any other form of remuneration must be separate from all other qualifications and clearly sealed separately in an envelope marked "costs" and on a separate file for the CD ROM marked "costs".
6. The responses must repeat the question, service, qualification, or requirement being answered and then follow with its bid, and each must be answered completely and in the order presented with consecutive page numbers. Any exhibits or appendices should follow in sequential order, and if an exhibit is supplied to respond to a requirement, then the answer should reference the exhibit and page number.
7. The name, title, address, phone number, and email address of the individual authorized to answer questions regarding your response to this RFQ.

Any response deemed incomplete by the KTRS evaluation team may not be considered in the evaluation. KTRS will accept all complete proposals that are properly submitted. However, KTRS reserves the right to request necessary amendments, reject any or all proposals in whole or in part, reject any proposal in whole or in part that does not meet the mandatory requirements, or cancel this RFQ, according to the best interest of the KTRS participants or the KTRS health plan.

### 3.2 TRANSMITTAL LETTER

The Transmittal Letter must address the following topics:

3.2.1 Identification

The transmittal letter must first identify the RFQ.

3.2.2 Summary of Ability and Desire to Supply the Required Services

The transmittal letter must briefly summarize the respondent's ability to supply the requested services. The letter must also contain a statement indicating the respondent's willingness to provide the requested services subject to the terms and conditions set forth in this RFQ.

3.2.3 Signature of Authorized Representative

A person authorized to commit the respondent to its representations must sign the transmittal letter. The transmittal letter shall include a certification that all information provided in the response is accurate and complete to the best of the respondent's knowledge, based upon due and diligent inquiry. Please also acknowledge that respondent understands any false or misleading information may result in disqualification from the RFQ at KTRS' discretion or may result in a breach of any contract, if awarded, as this entire RFQ document including the awarded respondent's entire response is to be incorporated by reference as an addendum to the final contract, if awarded.

3.2.4 Warranty

The Transmittal Letter signed by an authorized officer of respondent is also to confirm that respondent, its employees, officers, and agents have not paid, and will not pay, any remuneration directly or indirectly to KTRS or any of its members, officers, employees, agents, or any third party in connection with the RFQ or subsequent process, including, but not limited to, a finder's fee, cash solicitation fee, or a fee for consulting, lobbying, or otherwise.

**3.3 RESPONSE**

The response must contain the following items:

3.3.1 Ability to perform Scope of Work and other qualifications, Certification of Minimum Requirements and Questionnaire

Respondent should demonstrate in this section its ability to meet the requirements set forth in Attachments A through A6. And, that the respondent is in good standing with the Kentucky Department of Insurance and the Centers for Medicare and Medicaid Services.

The respondent must complete and provide Attachments A through A6 including the Mandatory Minimum Qualifications Compliance Certificate and the Questionnaire. If respondent is not able to certify as to all items in Attachment A through A6, the respondent's proposal will be considered unacceptable.

For the Attachments A through A6, it is very important that the respondent indicate anywhere that the plan design aspects can be satisfied or exceeded. Higher scores will be given to those qualified bidders that can exceed any existing plan design elements.

### 3.3.2 References

The respondent should include a list of at least three (3) clients for whom the respondent has provided Medicare Advantage Private Fee for Service plans and third party administrator services that are the same or similar to those services requested in this RFQ. Any state government or public health plan for which the respondent has provided these services should be included. Information provided should include the name, address, and telephone number of the client facility and the name, title, e-mail address, and phone/fax numbers of a person who may be contacted for further information.

### 3.3.3 Registration to do Business

Respondents proposing to provide services required by this RFQ are required to be registered to do business within the state by the Kentucky Secretary of State. It is the successful respondent's responsibility to complete the required registration with the Secretary of State.
The respondent must indicate the status of registration in this section of the response.

### 3.3.4 Compliance with Ethics Provisions

Any insurance carrier contracted with shall not engage in any conduct that violates or induces others to violate provisions in the Kentucky statutes regarding the conduct of public employees. Any insurance carrier contracted to offer the health plan services for our Medicare eligible participants described in this RFQ will be required to certify that each employee of the insurance carrier that interacts with State employees is aware of and shall abide by all ethical requirements that apply to persons who have a business relationship with the State, as set forth in Kentucky Revised Statutes, Chapter 11A, and Title 9 of the Kentucky Administrative Regulations. If you are not familiar with these ethical requirements, you should refer any questions to the Executive Branch Ethics Commission, or visit the Executive Branch Ethics Commission website at www.ethics.ky.gov. Any violation of these standards by an employee of the insurance carrier may result in KTRS (in its sole discretion) terminating the insurance carrier and third party administrator contract, if awarded.

### 3.3.5 Compensation for Services and Right to Negotiate

The respondent must agree to the method of compensation found in Attachment A5 for the services described in Attachments A through A6.

A contract may be awarded based on the initial proposals received without negotiation or discussion with the qualified bidders. The premiums, premium equivalents, fees, and any other forms of remuneration submitted with this RFQ should be the respondent's best offer, but KTRS reserves the right to conduct a negotiation phase with qualified bidders prior to determining if a bid will be awarded or prior to awarding a bid. Any agreements, modifications, or revisions shall be confirmed in writing by the qualified bidder as an amendment to the proposal under consideration prior to the close of the negotiation session. The RFQ requirements are not negotiable; however, KTRS reserves the right to amend the requirements if it is in KTRS' best interest or the best interest of our participants.

3.3.6 Conflicts

The respondent shall disclose any apparent or potential conflict of interest and any information that may impair the respondent's ability to provide the level of service required.

Please describe any involvement in matters adverse to the State of Kentucky or any of its agencies or instrumentalities. The bidder warrants that it has no current, pending or outstanding criminal, civil, or enforcement actions initiated by the State of Kentucky.

Please describe any involvement in matters adverse to the Centers for Medicare and Medicaid Services at both the state and federal level.

## SECTION FOUR
## RESPONSE EVALUATION

### 4.1 EVALUATION CRITERIA

KTRS has selected a group of qualified personnel to act as an evaluation team. The procedure for evaluating the responses against the evaluation criteria will be as follows:

1. Each response will be evaluated on the basis of the categories listed in the specific criteria below.
2. Based on the results of the evaluation, the respondents determined by KTRS to be qualified to offer the health plan services to our Medicare eligible participants described in this RFQ may be selected by KTRS for future benefits. KTRS reserves the right to reject any or all responses and award no bid as a result of this RFQ.
3. In addition, the evaluation team will consider other factors they believe to be material for this selection.

Responses will be evaluated based upon the proven ability of the respondent to satisfy the requirements in an efficient, cost-effective manner, taking into account quality of service with minimal tolerance for error.

Specific criteria include, but are not limited to:

1. Fulfilling the requirements and qualifications set forth in the RFQ;
2. Experience in offering Medicare Advantage Plans and the services of a third party administrator;
3. Competitiveness of the fee structure relative to other respondents; and
4. Quality, timeliness, and thoroughness of respondent's submission to this RFQ, which should clearly reflect and predict future performance.

The KTRS evaluation team will review all complete responses. References may be contacted. It is possible that a qualified respondent will be interviewed by persons participating in the evaluation or selection process. KTRS reserves the right, at its sole discretion, to require qualified bidders to make oral presentations/demonstrations and conduct site visits to verify or expand on any portion of this RFQ. In the event that KTRS determines that oral presentations/demonstrations are required, KTRS will provide the three highest ranked qualified bidders with the necessary information on the oral presentations/demonstrations and any site visits. KTRS reserves the right to reject any or all qualified responses in whole or in part based on the oral presentations/demonstrations and/or the site visit.

## 4.2 CONTRACT

If an award is made for 2007 and/or future, all portions of this RFQ document including the awarded respondent's entire response are to be incorporated by reference as an addendum to the final contract. Material breaches of information supplied in this RFQ will be considered material breaches of the entire contract, if awarded.

4.2.1 KTRS will not agree with any term or condition of a contract that:

1. Requires that suit be brought in any state other than Kentucky or that the contract be construed in accordance with the laws of any state other than Kentucky. KRS 45A.245 requires that all actions against the Commonwealth on contract must be brought in the Franklin Circuit Court and any contract must reflect the same. The Commonwealth's consent to be sued on contract claims shall not be construed as a waiver of its Eleventh Amendment rights, or as consent to be sued in federal court, or in any state court beyond the boundaries of Kentucky.
2. Requires KTRS to provide indemnity or hold a contractor harmless. The Kentucky Constitution, Section 230, provides that no money shall be drawn from the Treasury, but in pursuance of appropriations made by law. An agreement by KTRS to be obligated for a future indemnity is in essence committing money to be drawn from the Treasury without appropriation.
3. Requires KTRS to provide insurance except as determined necessary and appropriate by its Board of Trustees. Procurement of insurance shall not be construed as a waiver of sovereign immunity.
4. Does not permit KTRS to terminate the contract for cause or breach at any time pursuant to 200 KAR 5:312 Sections 1 and 2, or for convenience or non-appropriation of funds upon thirty-day written notice pursuant to 200 KAR 5:312 Sections 1, 3 and 4.
5. Requires KTRS to pay a retainer or make a deposit.
6. Requires limiting disclosure of the contract in violation of the Kentucky Open Records Act.
7. Requires KTRS to pay taxes. KTRS is tax exempt.
8. Requires mandatory resolution of disputes other than through the courts.
9. Requires modifying the statute of limitations or relating time within which a claim must be made under KRS 45A.260(2) or other applicable law.
10. That generally or specifically requires waiver of sovereign immunity.

4.2.2 Contract, if awarded, will be written to allow KTRS to self-fund the Medicare Advantage plan component once feasible.

4.2.3 Prices, fees, premiums, and premium equivalents and any form of remuneration submitted will be guaranteed for 180 days.

4.2.4 Contract, if awarded, will be written to revert to the self-funded Medicare Eligible Health Plan at the beginning of the next calendar year, if necessary, due to reduction of

Medicare subsidies in the Medicare Advantage program or if in the best interest of the plan participants or the health plan.

4.2.5 Contract, if awarded, shall be on a calendar year basis for the contract year and the benefit year.

4.2.6 Contract, if awarded, may explore any possibility of locking in premium rates and administrative fees for a two or three year period.

4.2.7 When the Executive Secretary of KTRS makes a written determination that funds are not appropriated or otherwise available to support continuation of performance of this contract, if awarded, this contract shall be canceled. A determination by the Executive Secretary that funds are not appropriated or otherwise available to support continuation of performance shall be final and conclusive.

4.2.8 This contract shall be construed in accordance with and governed by the laws of the State of Kentucky and suit, if any, must be brought in the State of Kentucky, Franklin County Circuit Court, Franklin County, Kentucky.

4.2.9 The awarded bidder, if any, agrees to indemnify, defend, and hold harmless KTRS, its agents, officers, and employees from all claims and suits including court costs, attorney's fees, and other expenses caused by any act or omission of the awarded bidder and/or its subcontractors, if any, in the performance of this contract, if awarded. KTRS shall **not** provide such indemnification to the awarded bidder.

4.2.10 If a contract is awarded, the awarded contractor and its employees shall comply with all applicable licensing standards, certification standards, accrediting standards and any other laws, rules or regulations governing services to be provided by the contractor pursuant to this contract. KTRS shall not be required to pay the contractor for any services performed when the contractor, its employees or subcontractors are not in compliance with such applicable standards, laws, rules or regulations. If licensure, certification or accreditation expires or is revoked, or if disciplinary action is taken against the applicable licensure, certification or accreditation, the contractor shall notify KTRS immediately and KTRS, at its option, may immediately terminate this contract.

4.2.11 Any inconsistency or ambiguity in this contract, if awarded, shall be resolved by giving precedence in the following order: (1) the contract, (2) attachments prepared by KTRS, (3) the RFQ, (4) awarded bidder's response to RFQ, and (5) attachments prepared by the awarded bidder. All attachments, and all documents referred to in this paragraph will be incorporated fully by reference to the final contract, if awarded.

4.2.12 All documents, records, programs, data, film, tape, articles, memoranda, and other materials not developed or licensed by the awarded bidder prior to execution of this contract, if awarded, but specifically developed under this contract shall be considered "work for hire" and the contractor transfers any ownership claim to KTRS and all such materials will be the property of KTRS. Use of these materials, other than related to contract performance by the contractor, without the prior written consent of KTRS, is prohibited. During the performance of this contract, the contractor shall be responsible for any loss of or damage to these materials developed for or supplied by KTRS and used to develop or assist in the services provided while the materials are in the possession of the contractor. Any loss or damage thereto shall be restored at the contractor's expense. Full, immediate and unrestricted access to the work product of the contractor during the term of this contract shall be available to KTRS.

4.2.13 If a contract is awarded, the awarded contractor shall provide professional liability insurance for its professional employees, public liability, property damage, and workers' compensation insurance, insuring as they may appear, the interest of all parties of the agreement and the KTRS Board of Trustees against any and all claims which may arise out of the contractor's operations under the terms of this contract. In the event that any carrier of such insurance exercises cancellation, notice of such cancellation shall be made immediately to KTRS.

**Attachment A**
**MANDATORY SCOPE OF WORK AND MANDATORY QUALIFICATIONS COMPLIANCE CERTIFICATE**

Unless otherwise specified, as of the response due date, respondents must satisfy all of the requirements outlined below and furnish all appropriate proof of compliance in order to be considered for award of the health services contract:

**1)** For calendar year 2007, qualified bidder must provide an insured Medicare Advantage Private Fee For Service plan on a full replacement basis to our Medicare eligible participants who have both Parts A and B of Medicare or are otherwise considered eligible for such plan. This is a mandatory bid component. For calendar years after 2007, should Medicare substantially reduce the subsidies afforded with the Medicare Advantage plan programs, KTRS will revert to the self-funded Medicare Eligible Health Plan for all participants, beginning with the next calendar year. The contract year and benefit year shall be the calendar year. The insurance carrier must be a Medicare awarded bidder to offer a Medicare Advantage Private Fee for Service plan in the State of Kentucky for 2007 and preferably 2006 with the intent of bidding this Kentucky product with Medicare through 2010, as long as Medicare continues to support and fund the subsidies afforded with a Medicare Advantage product in excess of traditional Medicare Parts A and B. Please provide written documentation to support this bid awarded by Medicare in 2006 and for 2007, upon receipt.

- **a.** Service offered must include analysis and application of requirements promulgated by state and federal laws, rules, and regulations as well as Medicare laws, rules, and regulations governing Medicare Advantage Private Fee For Service plans. This plan must be in compliance with all Medicare requirements for 2007.
- **b.** Plan design cannot be materially different than the existing 2006 plan design. Offering must allow KTRS to customize plan design, care management, and wellness programs. Wellness programs and care management programs, at a minimum, are to include a 24 hour nurse line for seniors, disease management programs applicable to a senior population, special fitness and discount programs for seniors, educational brochures/magazines applicable to seniors, case management for high cost claimants, and preventative senior care services. Complete Attachment A1 and A2.
- **c.** Participants' total out-of-pocket costs cannot be materially different than the existing 2006 deductible, copayments, coinsurance, and annual maximum cost amounts. Complete Attachment A3.

**d.** Since the Medicare Advantage Private Fee For Service solution is not network based, the awarded bidder must conduct a provider focused educational campaign. Ensure that participant disruption with providers of service is minimal with your Private Fee For Service platform that is consistent with our existing plan design. Perform aggressive provider communication campaign to necessary providers prior to January 2007. Especially, this campaign should reach out to the most highly utilized providers to verify that they understand and accept both Medicare and your Medicare Advantage Private Fee For Service programs. Every effort must be made to ensure comparability with the existing indemnity style physician and hospital access mechanism that KTRS participants currently enjoy. With a Private Fee For Service plan, Medicare renders capitated payments for administering a beneficiary's benefits. However, rather than building out an independent provider network, Private Fee For Service plans utilize traditional Medicare's participating physicians and provider payment rates. A Private Fee For Service plan is required to offer benefits that are at a minimum actuarially equivalent to the traditional Medicare program. Under special employer group waivers, the design of a Private Fee For Service plan can be enhanced to meet an individual plan sponsor's design objectives as long as the resulting plan meets Medicare's minimal coverage requirements. In your experience, with limited exception, confirm that most providers that accept Medicare assignment accept Medicare Advantage-Private Fee For Service since they are paid at the same Medicare reimbursement level. Complete the participant disruption analysis within this section of the RFQ.

**e.** Ensure that a passive enrollment will be performed electronically with no participant application process. Our participants with both Parts A and B will passively roll from the existing KTRS plan to the Medicare Advantage plan under the group enrollment process that Medicare has already established for prescription drug plans as follows. Please note that a similar provision will be included for Medicare Advantage organizations in section 40 of Chapter 2 of the Medicare managed care manual.

30.1.6 Group Enrollment for Employer/Union Sponsored PDPs

CMS has provided, under our authority to waive or modify Part D requirements that hinder the design of, the offering of, or the enrollment in an employer or union sponsored Part D retiree plans, a process for group enrollment in employer or union sponsored PDPs.

CMS will allow the employer group or unions to enroll its retirees (participants) using a group enrollment process that includes providing CMS with any information it has on other insurance coverage for the purposes of coordination of benefits.

The group enrollment process must include notification to each beneficiary as follows:

- All beneficiaries must be notified that the group intends to enroll them in a PDP that the group is offering; and
- That the beneficiary may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to group benefits opting out would bring; and
- This notice must be provided not less than 30 calendar days prior to the effective date of the beneficiary's enrollment in the group sponsored PDP.

Additionally, the information provided must include a summary of benefits offered under the group sponsored PDP, an explanation of how to get more information about the PDP, and an explanation on how to contact Medicare for information on other Part D options that might be available to the beneficiaries. Each individual must also receive the information contained on page 3 of Exhibit 1 of this guidance.

The employer group or union must provide all the information required for the PDP sponsor to submit a complete enrollment request transaction to CMS as described in this and other CMS Part D systems guidance. Refer to Appendix 2.

**f.** Provide performance guarantees equal to or better than those currently in place for fiscal year 2006. Complete Attachment A4.

**g.** Must comply with Medicare and Department of Labor standards on appeals and grievances. Must supply first and second level appeal services.

**h.** Consulting services must be provided on Medicare strategies and future changes at the federal and state level including cost containment strategies.

**i.** Provide all Medicare required communications to participants. Provide benefit summary and summary plan description to participants. Conduct yearly open enrollment if requested.

**j.** Working with the Medical Insurance Fund, its Executive Secretary, and staff in performing such other tasks and assuming such other responsibilities as are required and requested by the KTRS Board or the Executive Secretary consistent with this RFQ.

**k.** Ensure that all of the above is included in one simple, transparent premium per participant per month. Complete Attachment A5.

**2)** For calendar year 2007, qualified bidder must provide third party administrator services for the KTRS self-funded Medicare Eligible Health Plan, paying primary for those without Part A and secondary for those without Part B, for our Medicare eligible participants who are not eligible for the Medicare Advantage plan in one above or should the Medicare Advantage plan in one above no longer be financially beneficial to KTRS. This is a mandatory bid component, in that the awarded insurance carrier for the Medicare Advantage plan must also function as the third party administrator and claims processor for the existing KTRS self-funded Medicare Eligible Health Plan that will remain intact to cover participants who are not automatically entitled to Medicare Part A. The contract year and benefit year shall be the calendar year. The plan design and benefits for our participants without Part A of Medicare must be the same as the Medicare Advantage plan.

- **a.** Service offered must include the analysis and application of requirements promulgated by COBRA, HIPAA, the Public Health Services Act and any applicable state and federal laws, rules, and regulations governing self-funded state governmental health plan entities. This plan must be in compliance with all Medicare requirements for 2007.
- **b.** Plan design cannot be materially different than the existing 2006 plan design. Offering must allow KTRS to customize plan design, care management, and wellness programs. Wellness programs and care management programs, at a minimum, are to include a 24 hour nurse line for seniors, disease management programs applicable to a senior population, special fitness and discount programs for seniors, educational brochures/magazines applicable to seniors, case management for high cost claimants, and preventative senior care services. Complete Attachment A1 and A2.
- **c.** Participants' total out-of-pocket costs cannot be materially different than the existing 2006 deductible, copayments, coinsurance, and annual maximum cost amounts. Complete Attachment A3.

**d.** Ensure that participant disruption with providers of service is minimal. Perform aggressive provider communication campaign to necessary providers prior to January 2007. Every effort must be made to ensure comparability with the existing indemnity style physician and hospital access mechanism that KTRS participants currently enjoy. Complete participant disruption analysis included within this section of the RFQ.

**e.** Ensure that a passive enrollment will be performed electronically with no participant application process. Our participants without Parts A or B will passively remain on the self-funded Medicare Eligible Health Plan administered by awarded bidder.

**f.** Provide performance guarantees equal to or better than those currently in place for fiscal year 2006. Complete Attachment A4.

**g.** Must comply with Medicare and Department of Labor standards on appeals and grievances. Must supply first and second level appeal services.

**h.** Consulting services must be provided on Medicare strategies and future changes at the federal and state level including cost containment strategies.

**i.** Provide all Medicare required communications to participants. Provide benefit summary and summary plan description to participants. Conduct yearly open enrollment if requested.

**j.** Working with the Medical Insurance Fund, its Executive Secretary, and staff in performing such other tasks and assuming such other responsibilities as are required and requested by the KTRS Board or the Executive Secretary consistent with this RFQ.

**k.** Ensure that all of the above is included in one simple, transparent administrative fee per participant per month. Complete Attachment A5.

**l.** KTRS is to maintain claims fiduciary responsibility after first and second level appeals have been exhausted.

**Please note that if all qualified responses for one and two above demonstrate any material change from the existing KTRS plan or will be perceived as a material change by the KTRS participants, this RFQ process will cease.**

**Please describe the hospital pre-certification requirements that would be applicable to both mandatory components. It is important to KTRS that whatever pre-certification rules or any rules that exist for one plan component must exist for the other. It is pertinent that these two separate plans not be exposed to rules or requirements that are different. Those not automatically entitled to Medicare Part A should not be penalized in any way because they were a career teacher and were not eligible to pay into the Medicare fund.**

*Historical KTRS Medicare Eligible Health Plan Information:*

**Any historical data or census information supplied with this RFQ has been de-identified for the privacy sake of our participants.**

Monthly Participant Counts and Recorded Claims

For the 35 months ended May 2006, the following table details monthly participant counts and recorded medical claims for the existing KTRS Medicare Eligible Health Plan. The claims figures represent recorded claims, and they have not been adjusted for accruals or IBNR. It should be noted that a retiree enrolling in Medicare Part D is the only instance that a KTRS retiree is allowed to take a medical only plan. For 2006, the KTRS benefit year is the calendar year, and the fiscal year ends June 30th. This RFQ proposes that the KTRS benefit and contract year shall be the calendar year. In 2006, KTRS did revise its payment methodology to more closely follow Medicare's payment strategy, in that KTRS is complimenting Medicare and will pay secondary on a claim only when Medicare pays primary. There are currently less than 2,000 retirees that are eligible to enroll but waive the existing KTRS Medicare Eligible Health Plan.

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fiscal Year 2004 | Jul-03 | Aug-03 | Sep-03 | Oct-03 | Nov-03 | Dec-03 | Jan-04 | Feb-04 | Mar-04 | Apr-04 | May-04 | Jun-04 | | |
| Total Participants | 18,309 | 18,350 | 18,390 | 18,399 | 18,423 | 18,430 | 18,406 | 18,417 | 18,422 | 18,433 | 18,449 | 18,482 | | |
| MEHP Medical Claims Recorded | $1,157,833 | $1,284,107 | $1,433,342 | $1,449,716 | $1,250,975 | $1,384,204 | $1,474,462 | $1,223,739 | $1,280,316 | $1,358,102 | $1,123,674 | $1,366,073 | $15,786,543 | Total |
| | | | | | | | | | | | | | | |
| Fiscal Year 2005 | Jul-04 | Aug-04 | Sep-04 | Oct-04 | Nov-04 | Dec-04 | Jan-05 | Feb-05 | Mar-05 | Apr-05 | May-05 | Jun-05 | | |
| Total Participants | 18,617 | 18,654 | 18,682 | 18,714 | 18,757 | 18,788 | 18,801 | 18,830 | 18,833 | 18,837 | 18,868 | 18,919 | | |
| MEHP Medical Claims Recorded | $1,404,607 | $2,036,538 | $1,632,463 | $1,782,378 | $1,461,333 | $1,680,135 | $1,485,861 | $1,441,004 | $1,251,669 | $1,843,518 | $1,510,694 | $2,071,686 | $19,601,886 | Total |
| | | | | | | | | | | | | | | |
| Fiscal Year 2006 | Jul-05 | Aug-05 | Sep-05 | Oct-05 | Nov-05 | Dec-05 | Jan-06 | Feb-06 | Mar-06 | Apr-06 | May-06 | Jun-06 | | |
| Total Participants | 19,025 | 19,076 | 19,134 | 19,197 | 19,242 | 19,259 | 19,302 | 19,316 | 19,339 | 19,333 | 19,340 | - | | |
| MEHP Medical Claims Recorded | $1,470,428 | $1,715,043 | $1,419,555 | $1,684,742 | $1,854,283 | $1,540,478 | $1,758,038 | $1,515,110 | $1,487,664 | $1,614,162 | $2,205,288 | | $18,264,791 | Total 11 Months Only |
| | | | | | | | | | | | | | $19,925,226 | Annualized |

KTRS Premium Equivalent Contribution Supplement Percentages for 2006

The KTRS premium equivalent contribution supplement percentages beginning calendar year 2005 are in the following table. KTRS pays 100% of the premium equivalent for approximately 86% of our Medicare eligible retirees who have 20 or more years of service. Medicare eligible dependants pay the full monthly premium equivalent.

| Years of Service | Medicare Eligible with Hire Date Before 07/01/2002 with Birthday Rule | | Medicare Eligible with Hire Date on or After 07/01/2002 and No Birthday Rule |
|---|---|---|---|
| | 65th Birthday Prior to 01/01/05 | 65th Birthday on or after 01/01/05 | |
| 5 – 9.99 | 70% | 25% | 10% |
| 10 – 14.99 | 80% | 50% | 25% |
| 15 – 19.99 | 90% | 75% | 45% |
| 20 – 24.99 | 100% | 100% | 65% |
| 25 – 25.99 | 100% | 100% | 90% |
| 26 – 26.99 | 100% | 100% | 95% |
| 27 or more | 100% | 100% | 100% |

Participant Census Data

Provided separately on CD only, is the May 2006 census of the Medicare Eligible Health Plan participants that details date of birth, gender code, and residential zip code in Excel given the file name of "Census MEHP Participants May 2006.xls". This file contains 19,178 individual participants. Please return this CD to KTRS' attention with your response. Please note that approximately 1,428 of the total 19,178 participants do not have and are not automatically entitled to Medicare Part A, as they have never paid into Social Security or Medicare. The May 2006 census information for the 1,428 participants without Part A of Medicare is located in the file named "Census MEHP Participants Without Part A May 2006.xls". Claims information on the KTRS participants without Part A of Medicare is discussed below.

Participants Without Part A of Medicare

Total claims for all participants are provided in the historical recorded claims above, but according to the current KTRS third party administrator, recorded claims for our participants without Part A of Medicare for fiscal year 2004 and 2005 are as follows:

| FY Ended | Claims Paid As Primary Payer | Subtract ESRD Claims | Claims Paid for those Participants Without Part A of Medicare |
|---|---|---|---|
| 2005 | $ 2,101,937 | $(701,342) | $ 1,400,595 |
| 2004 | $ 1,187,483 | $(410,584) | $ 776,899 |

The current KTRS third party administrator generated this query by reviewing claims paid where their adjudication process indicated that KTRS was the primary payer, as opposed to secondary under normal circumstances. However, KTRS performed an internal query of the claims data tapes supplied by our third party administrator and cross-matched the claims data to the Health Insurance Claim Numbers (HICN) housed on the KTRS database where the HICN suffix was "M" indicating that the beneficiary had Part B of Medicare only. This query produced higher claims paid amounts for our participants without Part A of Medicare as follows in the table below, but these figures do include Part B and Part A charges:

| Period | Claims Count | Claims Paid for those Participants Without Part A of Medicare |
|---|---|---|
| Fiscal Year 2005 | | $5,701,519 |
| 12 Months Ended 03/31/2006 | 24,992 | $5,826,624 |

KTRS has previously done a feasibility study of paying the Medicare Part A premiums for these participants. It is not probable that this arrangement could be structured with Medicare, and this would produce a taxable event for this subsection of our participants. Also, the net claims costs to KTRS for the 1,428 participants without Part A of Medicare appear to be below the projected cost of paying their Part A premiums for 2007, calculated as follows:

| Approximate Number of Participants without Part A of Medicare as of May 2006 | Projected 2007 Medicare Part A Monthly Premium (2006 = $393) | 2007 Projected Annual Cost of KTRS Paying Part A of Medicare |
|---|---|---|
| 1,428 | $ 425 | $ 7.3 Million |

Given this information, KTRS will be requesting in the cost section, Attachment A5, of this RFQ that the third party administrator services for the self-funded Medicare Eligible Health Plan be quoted with and without stop loss coverage with an aggregate annual limit of $7.3 million and no individual limits.

Provider Access/Participant Disruption Analysis

Included on the CD is a file named "Provider TIN Claims Summary Thru 03312006Revised.xls" representing recorded claims by TIN for the twelve months ended 03/31/2006. The report is sorted by the highest number of unique claimants/patients visiting each unique provider number. According to our existing third party administrator, the first row of data with a zero TIN number and with the highest number of unique claimants represents payments made directly to the patient.

Please perform an analysis in Excel indicating which providers are currently paying claims under your existing Medicare Advantage Private Fee For Service plan. For those that are not, please provide a detailed explanation of the provider communication campaign and strategy that would take place prior to January 01, 2007. KTRS understands that a provider will be paid using the same Medicare fee schedule under the Medicare Advantage Private Fee For Service product as being used under traditional Medicare Parts A and B. Therefore, there is no financial disincentive for a provider that already accepts traditional Medicare. Given that disruption to the KTRS participants must be minimal, please structure your answer regarding provider communication strategy in three levels: (1) providers seeing 100 or greater than 100 unique claimants; (2) providers seeing between 10 and 99 unique claimants; and (3) providers seeing less than 10 unique claimants.

Other Documents

- The KTRS existing and entire Summary Plan Description for the Medicare Eligible Health Plan is located on our website at www.ktrs.ky.gov. For bids rendered, there are to be no material deviations from the Summary Plan Description.

- The KTRS Comprehensive Annual Financial Report for 2005 is located on our website at www.ktrs.ky.gov.

Plan Design Elements Attachment A1—Both plan components must be the same. You must match or exceed the 2006 plan design elements. Higher scores will be given where you exceed.

| 2006 Medicare Service | 2006 Medicare Benefits | 2006 Medicare Pays (Eligible Expenses) | 2006 Medicare Plus KTRS Benefits Pays after Applicable KTRS Deductibles and Copayments (Eligible Expenses) | Prospective Bidder's Plan Pays--Match or Exceed? |
|---|---|---|---|---|
| **PART A:**<br>**Inpatient Hospital Services**<br>Semiprivate room and board, miscellaneous hospital services and supplies such as drugs, X-rays, lab tests and operating room | 61st through 90th day<br>91st through 150th day<br>(Lifetime Reserve Days)<br>Beyond 150 days | All but $238 a day<br>All but $476 a day<br><br>- 0 - | All but $47.60 (days 61 - 90)<br>All but $95.20 (days 91 - 150)<br><br>No coverage beyond days 150 | |
| **Blood** | Blood | All costs except Medicare blood deductible (the cost of the first 3 pints) each calendar year, unless paid for under Part B | Coverage of 96% of first 3 pints and 100% of remaining expenses | |
| **PART B**<br>**Medical Expenses** | Services of a physician, outpatient services | 80% of eligible expenses after $124 deductible | 96% Covered | |
| **Medical Supplies**<br>(other than prescription drugs) | Supplies | 80% of eligible expenses after $124 deductible | 96% Covered | |
| **Blood** | Blood | 80% of eligible expenses for cost of blood except Medicare blood deductible (the cost of the first 3 pints) each calendar year, unless paid for under Part A | Coverage of 96% of first 3 pints and 100% of remaining expenses | |
| **Miscellaneous**<br>Immunosuppressive medications | Outpatient medications following a transplant | 80% of eligible expenses after $124 deductible for one year beginning with the date of discharge from the inpatient hospital stay during which a Medicare-covered organ transplant was performed | 96% Covered | |
| **PART A:**<br>**Part A Deductible** | $952 per benefit period | - 0 - (Please note: Medicare pays all other eligible expenses for inpatient hospital services during the 1st through 60th day ) | All but $250 per admit (days 1-60) | |
| **Private Room** | Private Room | Semiprivate average cost | Semiprivate average cost | |
| **In-hospital Private-duty Nursing Care** | Medically necessary nursing care by a private-duty nurse while in the hospital | - 0 - | Not Covered | |
| **Skilled Nursing Facility Care (following a related covered hospital stay of at least three days)** | First 20 days<br>21st through 100th day<br>Beyond 100 days | 100% of cost<br>All but $119.00 a day<br>- 0 - | 100% Covered (days 1 - 20)<br>All but $24 per day (days 21 - 100)<br>No Coverage beyond 100 days | |
| **Parts A & B Home Health Care** | Part-time or intermittent skilled nursing care and physical or speech therapy | Full cost of eligible expenses, except durable medical equipment is paid at 80% | 100% of eligible expenses covered , except durable medical equipment is paid at 96% | |
| **PART B:**<br>**Inpatient Prescription Drugs** | Cost of inpatient prescription drugs | Same as inpatient hospital services | Same as inpatient hospital services | |
| **Hospice** | Medically necessary hospice care | Eligible expenses for hospice care except for 5% of eligible expenses for inpatient respite care during a benefit period, and 5% of eligible expenses for outpatient prescription drugs or $5 toward each prescription, whichever is less | Eligible expenses for hospice care except for 1% of eligible expenses for inpatient respite care during a benefit period, and 1% of eligible expenses for outpatient prescription drugs or $1 toward each prescription, whichever is less | |
| **Non-hospital Outpatient Treatment For Mental and Nervous Conditions** | Medically necessary services | 50% of eligible expenses | 50% Covered | |
| **Care Received Outside of U.S.A.** | | - 0 - | 80% Covered with $5000 annual maximum benefit after applicable copayments and deductibles. True urgent/emergent medical care during any temporary stay is considered a covered benefit. | |
| **Care Management and other Value Added Programs** | N/A | N/A | Currently not offered with existing plan design but the following will be mandatory requirements for this Medicare Advantage bid:<br>1. 24 Hour Nurse Line for Seniors<br>2. Disease Management Programs Focused on Seniors<br>3. Special Fitness and Discount Programs for Seniors<br>4. Educational Brochures and/or Magazines for Seniors<br>5. Care Management for High Cost Claimants<br>6. Preventative Care Services | |

Coverage Exceptions Attachment A2—Both plan components must have the same exceptions. You must indicate yes or no for each plan component.

| **SUMMARY OF EXISTING 2006 MEHP MEDICAL COVERAGE**<br><br>GENERAL EXCLUSIONS NOT COVERED BY MEDICARE PART A, MEDICARE PART B, AND THE CURRENT MEHP<br><br>Items and services not covered include, but are not limited to: | **Proposed Medicare Advantage Plan Private Fee For Service Covers?** | **Proposed Self-funded Medicare Eligible Health Plan Covers?** |
|---|---|---|
| ❑ Acupuncture. | **Yes or No** | **Yes or No** |
| ❑ Deductibles, coinsurance, or copayments when you get health care services. | **Yes or No** | **Yes or No** |
| ❑ Dental care and dentures (with only a few exceptions). | **Yes or No** | **Yes or No** |
| ❑ Cosmetic surgery. | **Yes or No** | **Yes or No** |
| ❑ Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home. | **Yes or No** | **Yes or No** |
| ❑ Doctor's charges which are in excess of the amount determined to be acceptable by Medicare. | **Yes or No** | **Yes or No** |
| ❑ Eye refractions. | **Yes or No** | **Yes or No** |
| ❑ Health care you get while traveling outside of the United States (except in limited cases). | **Yes or No** | **Yes or No** |
| ❑ Hearing aids and hearing exams for the purpose of fitting a hearing aid. | **Yes or No** | **Yes or No** |
| ❑ Hearing exams (screening) (except in limited cases). | **Yes or No** | **Yes or No** |
| ❑ Intermediate nursing home care costs. | **Yes or No** | **Yes or No** |
| ❑ Long-term care, such as custodial care in a nursing home. | **Yes or No** | **Yes or No** |
| ❑ Orthopedic shoes (with only a few exceptions). | **Yes or No** | **Yes or No** |
| ❑ Prescription drugs—most prescription drugs are not covered. | **Yes or No** | **Yes or No** |
| ❑ Routine foot care (with only a few exceptions). | **Yes or No** | **Yes or No** |
| ❑ Routine eye care and most eyeglasses (see the 2006 Medicare & You Handbook). | **Yes or No** | **Yes or No** |
| ❑ Routine or yearly physical exams. (If your Part B coverage begins on or after January 1, 2005, Medicare will cover a one-time physical examination within the first six months you have Part B.) | **Yes or No** | **Yes or No** |
| ❑ Screening tests and labs except those listed in the 2006 Medicare & You Handbook. | **Yes or No** | **Yes or No** |
| ❑ Services or supplies that are not medically necessary or that are investigative in nature. | **Yes or No** | **Yes or No** |
| ❑ Shots (vaccinations) except those listed in the 2006 Medicare & You Handbook. | **Yes or No** | **Yes or No** |
| ❑ This plan does not cover: any expense that is not a Medicare Eligible Expense or beyond the limits imposed by Medicare for such expenses or excluded by name or specific description by Medicare, except as specifically provided in this booklet; any portion of a covered expense to the extent paid by Medicare; or expenses incurred after coverage terminates including a person being treated or confined to a hospital when his or her health expense coverage ceases. | **Yes or No** | **Yes or No** |

Cost Sharing Elements Attachment A3—Must be the same for both plan components. You must match or exceed the 2006 cost sharing elements. Higher scores will be given where you exceed.

| **SUMMARY OF EXISTING 2006 MEHP MEDICAL COVERAGE**<br><br>DEDUCTIBLE, COPAYMENTS, COINSURANCE, AND MAXIMUM LIMITS FOR MEDICAL CLAIMS WITH THE MEDICARE ELIGIBLE HEALTH PLAN (MEHP) | **Proposed Medicare Advantage Plan Private Fee For Service—Match or Exceed?** | **Proposed Self-funded Medicare Eligible Health Plan—Match or Exceed?** |
|---|---|---|
| **Benefit Period.....Calendar Year** | | |
| **Medical Deductible ….....…….....$150.00**<br>· This annual $150.00 deductible applies to approved medical expenses for covered services, except prescription drugs, unless otherwise indicated.<br>· Applies to maximum annual out-of-pocket limit for covered expenses. | | |
| **Inpatient Hospital Copayment Per Admission** ..…….....**$250.00**<br>· This $250.00 copayment is applicable to each hospital admission to be applied once during any 60-day period.<br>· Applies to maximum annual out-of-pocket limit for covered expenses. Once the maximum annual out-of-pocket limit for covered expenses is met, this copayment will be waived for the remainder of the calendar year.<br>· Charges subject to this copayment are not subject to the Medical Deductible above. | | |
| **Outpatient Surgery Copayment Per Admission ……....$125.00**<br>· This $125.00 copayment is applicable to each outpatient surgery facility charge to be applied once during any 60-day period.<br>· Does not apply to maximum annual out-of-pocket limit for covered expenses. Once the maximum annual out-of-pocket limit for covered expenses is met, this copayment will not be waived for the remainder of the calendar year.<br>· Charges subject to this copayment are subject to the Medical Deductible above. | | |
| **Covered Person Payment Percentage**<br>· (CoInsurance) 20% after annual medical deductible and applicable copayments. | | |
| **Covered Person Reduced Payment Percentage For Non-Emergency Care in an Emergency Room**<br>· (CoInsurance) 50% after annual medical deductible and applicable copayments. | | |
| **Maximum Annual Out-of-pocket Limit For Covered Expenses: $1,200 Per covered person, per benefit period,** including the medical deductible and the inpatient hospital copayment per admission. The outpatient surgery copayment per admission is excluded. See above for specific applications. | | |
| **Maximum Lifetime Benefit: $1,500,000 per covered person.** | | |
| **YOUR COVERAGE IS NOT EFFECTIVE WITHOUT PART B OF MEDICARE**<br>Any benefits payable, or which would be payable under Medicare Part B, will be deducted from the medical expenses covered under this plan before benefits of the plan are determined. If you are not enrolled in Part B you will be responsible for the portion that would have been paid by Medicare had you been enrolled in Part B. | | |

Performance Guarantee Elements Attachment A4—Must be the same for both plans. You must match or exceed the 2006 performance guarantee elements. Higher scores will be given where you exceed.

| ***Performance Guarantee Category:*** | **Guarantee:** | **Proposed Medicare Advantage Plan Private Fee For Service—Match or Exceed?** | **Proposed Self-funded Medicare Eligible Health Plan—Match or Exceed?** |
|---|---|---|---|
| ***ID Card Production and Distribution*** | Produce and distribute ID cards, in the name of each individual participant, within 10 days of notification of new participant coverage or a valid status change. | | |
| ***Overall Account Management*** | Services (i.e., on-going financial, eligibility, drafting, and benefit administration and continued customer support) provided by the Field Marketing Staff and/or the Employer Service Team during the guarantee period will be satisfactory to Kentucky Teachers' Retirement System. | | |
| ***Management Reporting*** | Provide Kentucky Teachers' Retirement System with paid claim reports within 30 days after the end of the reporting period and incurred claims reports within 120 days after the end of the reporting period. | | |
| ***Renewal Information Delivery*** | Provide Kentucky Teachers' Retirement System with renewal fees and/or premium equivalents, and claim projections for the upcoming calendar year by August 1 provided the benefit plan has been defined as of that date. Calendar Year End Accounting Results will be delivered by May 1. | | |
| ***Claim Administration--Turnaround Time*** | Claim turnaround time during the guarantee period will not exceed 30 calendar days for 98% of the processed claims on a cumulative basis each guarantee period. | | |
| ***Claim Administration--Financial Accuracy*** | Annual dollar accuracy of the claim payment dollars will be 99.0% or higher. | | |
| ***Claim Administration--Coding/Statistical Accuracy*** | Annual coding accuracy will be 99.0% or higher. | | |
| ***Claim Administration--Payment Incidence Accuracy*** | Annual payment incidence accuracy will be 98% or higher. | | |
| ***Participant Satisfaction*** | Guarantee a positive response rate of 80% or better on the standard Balanced Scorecard Participant Satisfaction survey. | | |
| ***Telephone Response Time--Abandonment Rate*** | Average rate of telephone abandonment will not exceed 4% for the guarantee period. | | |
| ***Telephone Response Time--Average Speed of Answer*** | Average speed of answer for the modular unit providing Kentucky Teachers' Retirement System's customer service will not exceed 30 seconds for the guarantee period. | | |

Cost Elements Attachment A5—**Must be returned in a separate envelope.**

| Mandatory Bid Component | Approximate Participants Per Month | Administrative Fee Per Participant Per Month | Premium Per Participant Per Month | Stop Loss Coverage Per Participant Per Month (Annual Aggregate of $7.3 Million Only) |
|---|---|---|---|---|
| **1. Medicare Advantage Private Fee For Service** | 17,750 | N/A | $_____** | N/A |

**The 2007 premium per participant per month for the Medicare Advantage plan must be awarded by Medicare and documentation will be required. Under the new Medicare Advantage bidding process, Medicare establishes a benchmark for local and regional Medicare Advantage plans. For local Medicare Advantage plans, the Medicare Advantage area-specific non-drug benchmark amount is equal to the monthly Medicare Advantage capitation rate for the local area. When multiple service areas are involved, a weighted average benchmark is established. If a bid submitted by a Medicare Advantage plan is lower than the benchmark, 25% goes to Medicare, and 75% of the difference is a rebate amount that must be used to:

- ❑ provide extra benefits,
- ❑ reduce the beneficiary's cost sharing for Parts A & B services,
- ❑ reduce the beneficiary's Part B premium,
- ❑ reduce the beneficiary's premium for the plan's supplemental benefits;
- ❑ or, a combination of the above.

In other words, plans with costs below their Medicare payments must distribute savings to beneficiaries as lower plan premiums and copayments, additional benefits, or a reduction in Part B premiums; or plans can contribute to a reserve fund. If a plan's bid is higher than the applicable benchmark, the enrollee will pay the difference.

| | | | | |
|---|---|---|---|---|
| **2. Self-Funded Medicare Eligible Health Plan** | 1,428 | $_____ | N/A | $_____ |

*Acknowledgements by Qualified Bidder*

- ❑ Must supply one simple transparent administrative fee per participant per month and one simple premium per participant per month and this cost is to cover Attachments A through A6 in its entirety. No costs are to be reported in alacarte fashion.
- ❑ For the self-funded Medicare Eligible Health Plan, must supply one s imple transparent stop loss coverage per participant per month figure for an annual aggregate of $7.3 million only. There is to be no individual stop loss limits.
- ❑ The administrative fee per participant per month will be tied to a most favored nations clause in the final contract, if awarded.
- ❑ If either mandatory bid component above is being offered with supplemental dental, hearing, or vision coverage, then please remove from your cost offering. KTRS does not currently offer supplemental dental, hearing, or vision coverage and does not desire to do so in the future.
- ❑ KTRS is not to be charged separately for printing and postage for all standard and Medicare required mailings, including Summary Plan Descriptions, benefit summaries, enrollment kits, welcome kits, etc.
- ❑ For premiums and administrative fees paid before the 30-days typically allowed, a discount of five percent will be applied for payments made within five business days.
- ❑ KTRS has a fiduciary responsibility to our participants that insurance carriers and third party administrators do not experience unreasonable profit margins at the expense of our participants and the plan. Therefore, full transparency of your retention must be supplied to KTRS.
    - o You must supply your expected and actual 2007 retention from the Medicare Advantage plan supplied to KTRS in both percentage and actual dollars, and further broken down by administrative costs, risk margin, and profit margin.
- ❑ You must agree that any future retention and administrative fee increases beyond 2007 will be tied to the current CPI-U for Medical Services.

If the 2007 Medicare Advantage plan actual claims costs are less than 90% of the premiums collected from KTRS, then that additional amount will be returned to KTRS to help stabilize the Medical Insurance Fund.

**QUESTIONNAIRE Attachment A6 Provided Separately**

The questionnaire found in Attachment A6 must be completed and included with the response. The questionnaire has been prepared to obtain responses relative to the respondent's capability to successfully provide all required services.

**MANDATORY SCOPE OF WORK, QUESTIONNAIRE, AND MANDATORY QUALIFICATIONS COMPLIANCE CERTIFICATE**

Unless otherwise specified, as of the response due date, respondents must satisfy all of the requirements outlined in this RFQ and specifically Attachments A through A6 and furnish all appropriate proof of compliance in order to be considered for award of the health services contract.

It is understood that failure to sign and return this statement and accompanying documentation with the response to this RFQ will render the respondent’s response invalid.

If you cannot offer both mandatory plan components as exhibited in all of Attachments A through A6 and this RFQ, then please, in the interest and respect of your time and that of KTRS, please do not sign below and do not submit a response to this RFQ.

Company: _____ Signature: _____

Title: _____ Date: _____